In the Court of Common Pleas of MONTGOMERY County, Pennsylvania

DOMESTIC RELATIONS SECTION

DOMESTIC RELATIONS, PO BOX 311, NORRISTOWN, PA. 19404-0311

Phone: (610) 278-3646 **Fax:** (610) 239-9637

	)	Docket Number:
	Plaintiff)	
vs.	)	PACSES Case Number:
	)	
	Defendant)	Other State ID Number:

Please note: All correspondence must include the PACSES Case Number.

Income Statement

THIS FORM MUST BE FILLED OUT AND YOU MUST PROVIDE DOCUMENTS TO SUPPORT ALL AMOUNTS PROVIDED IN THIS INCOME STATEMENT

(If you are self-employed or if you are salaried by a business of which you are owner in whole or in part, you must also fill out the Supplemental Income Statement which appears below.)

INCOME STATEMENT OF

_____

(Name) (PACSES Number)

I verify that the statements made in this Income Statement are true and correct. I understand that false statements herein are made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

Date: _____ _____

Plaintiff or Defendant

INCOME

Employer: _____

Address: _____

Type of Work: _____

Payroll Number: _____

Pay Period (weekly, biweekly, etc): _____

Gross Pay per Pay Period	$	_____
Itemized Payroll Deductions:		_____
Federal Withholding	$	_____
FICA		_____
Local Wage Tax		_____
State Income Tax		_____
Mandatory Retirement		_____
Union Dues		_____
Health Insurance		_____
Other (specify)		
_____		_____
_____		_____

Net Pay per Pay Period: $ _____

Income Statement (Continued) PACSES Case Number:

Other Income:

	Week	Month	Year
		(Fill in Appropriate Column)	
Interest	$	$	$
Dividends			
Pension Distributions			
Annuity			
Social Security			
Rents			
Royalties			
Unemployment Comp.			
Workers Comp.			
Employer Fringe Benefits			
Other			
		$	$
TOTAL INCOME		$	

PROPERTY OWNED

	Description	Value	Ownership* H	W	J
Checking accounts		$			
Savings accounts					
Credit Union					
Stocks/bonds					
Real Estate					
Other					
	Total	$			

INSURANCE

	Company	Policy No.	Coverage* H	W	C
Hospital					
Blue Cross					
Other					
Medical					
Blue Shield					
Other					
Health/Accident					
Disability Income					
Dental					
Other					

*H=Husband; W=Wife; J=Joint; C=Child

SUPPLEMENTAL INCOME STATEMENT (You only need to complete the below portion if you are self-employed or if you are salaried by a business of which you are owner in whole or in part)

(a) This form is to be filled out by a person (check one):
- ○ (1) who operates a business or practices a profession, or
- ○ (2) who is a member of a partnership or joint venture, or
- ○ (3) who is a shareholder in and is salaried by a closed corporation or similar entity.

(b) Attach to this statement a copy of the following documents relating to the partnership, joint venture, business, profession, corporation or similar entity:

(1) the most recent Federal Income Tax Return, and
(2) the most recent Profit and Loss Statement.

(c) Name of business: _____

Address and telephone number: _____

_____

(d) Nature of business

(check one)
- ○ (1) partnership
- ○ (2) joint venture
- ○ (3) profession
- ○ (4) closed corporation
- ○ (5) other

(e) Name of accountant, controller or other person in charge of financial records:

_____

(f) Annual income from business: _____

(1) How often is income received? _____

(2) Gross income per pay period: _____

(3) Net income per pay period: _____

(4) Specific deductions, if any: _____

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vs.

Plaintiff) Docket Number:
)
) PACSES Case Number:
)
Defendant) Other State ID Number:

Please note: All correspondence must include the PACSES Case Number.

Guidelines Expense Statement

EXPENSE STATEMENT OF

_____

(Name) (Pacses Number)

I verify that the statements made in this Expense Statement are true and correct. I understand that false statements herein are made subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

Date: _____ _____

Plaintiff or Defendant

Instructions: Guidelines Expense Statement - This form should only be completed when:

1) You are requesting an adjustment to the amount of support pursuant to Rule 1910.16-5 because of unusual needs and unusual fixed obligations, other support obligations, medical expenses not covered by insurance, or any other relevant factors, or

2) You are requesting that the other party share in the following expenses pursuant to Rule 1910.16-6: child care expenses, health insurance premiums, unreimbursed medical expenses, private school tuition, summer camp, or other needs, or mortgage payment.

You must provide documents to support all amounts provided in this Expense Statement

	Weekly	Monthly	Yearly
	(Fill in Appropriate Column)		
Mortgage (including real estate taxes and homeowner's insurance) or Rent	$	$	$
Health Insurance Premiums			
Unreimbursed Medical Expenses:			
Doctor			
Dentist			
Orthodontist			
Hospital			
Medicine			
Special Needs (glasses, braces, orthopedic devices, therapy)			

	Weekly	Monthly	Yearly
Child Care			
Private School			
Parochial school			
Loans/Debts			
Support of Other Dependents:			
Other child support			
Alimony payments			
Other: (Specify)			
Total	$	$	$